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ABSTRACT

The tendency in the United States to view the nursing home as an all-purpose solution to the health problems of the elderly has created a set of self-made problems: increased dependency, depression and social isolation among the aged. In the United States, unlike in many European nations, institutional care of the elderly is conceived of and financed as a health service rather than a social service, even though institutional placement provides a complete social context for an individual and obviously constitutes a rather dramatic social intervention. It is also clear that the American method of financing creates disincentives to rehabilitation. Alternatives to nursing home care should be considered, as well as a formula for reimbursing nursing homes to make them more supportive of positive efforts to provide effective care. (Author)

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OLD PROBLEMS IN NEED OF NEW SOLUTIONS

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April 1978

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CARE OF THE AGED:
OLD PROBLEMS IN NEED OF NEW SOLUTIONS

Robert Kane and Rosalie Kane

SUMMARY

The ever-present needs of the elderly have been exacerbated by the stresses on the modern American family. The need for conceptual work to forge out a humanitarian and effective system of care becomes even more crucial. We are not as advanced in this task as some European countries, which benefit from smaller geographic areas, more homogeneous populations, and rationalized systems of health care. As we have pointed out, most forms of care for the elderly--including primary care, home health care, mental health services, sheltered housing, and day care--are woefully underdeveloped in the United States, while institutional nursing home care has become the catch-all service.

The enormous task ahead requires simultaneous planning on a number of fronts. Ultimately, we would hope the provision of institutional long-term care might be organized as a social service with an important health delivery component rather than the reverse as is now the case. In the meantime, we have made some suggestions about ways to change the reverse incentives which now reward nursing homes according to the extent of the patient's disability. In the American context, it also appears that non-physician practitioners are able to raise to a new level an arena of care that has largely been abandoned by the physician.

Experience abroad suggests that long-term care programs are not really interchangeable; a well developed home health program, for example, does not obviate the need for high quality institutional care. As we proceed in the next decade to develop a comprehensive national plan for care for the elderly, we urge that it include a range of options for patients and their families rather than depend on a pat formula.

In a large, multiethnic, multiracial, geographically dispersed society such as the United States, local control and local imagination will be required to meet local problems creatively. The federal challenge is then to provide adequate inducements to ensure that care of the elderly is given sufficient priority in all areas of the country.

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INTRODUCTION

Health practitioners are constantly admonished that they must minister to the whole person--nowhere is this proviso more relevant than in the care of the elderly. Otherwise there is a danger that in trying to meet the very real health needs of the aged, we will exacerbate the social and psychological problems of a group already vulnerable because of the losses associated with the aging processes. The nursing home, as an all-purpose solution to the health problems of the elderly has created a set of iatrogenic problems; increased dependency, depression, and social isolation among the aged.[1] In the United States, unlike in many European nations, institutional care of the elderly is conceived of and financed as a health service rather than a social service even though institutional placement provides a complete social context for an individual and obviously constitutes a rather dramatic social intervention.

In this paper, we shall briefly describe the nursing home in the context of other long-term care alternatives, describe the population found in nursing homes, discuss some of the issues (drawing on examples of long-term care abroad as well as in the United States), and then indicate ways that the financing of nursing home care creates disincentives to rehabilitation. We shall conclude by suggesting alternatives to nursing home care and, perhaps more realistically, a formula whereby the reimbursement of nursing homes might become more supportive of positive efforts to provide more effective care.

In the United States today, the nursing home has become the symbol of the inadequacy of the health system in meeting the needs of the elderly. If the public would prefer to ignore the nursing home out of shame, it is forced to confront it out of fiscal necessity. Health care costs of the elderly rose from $8.2 billion in 1966 to $34.9 billion (or 29 percent of the nation's total health care bill) in 1976, an increase of 190 percent in real dollars. In the decade since Medicare, however, the locus of care has also shifted. In 1966 15 percent of health care expenditures for the elderly was in nursing homes, and by

1977 that proportion had risen to 23 percent. Although those over 65 use a disproportionate amount of almost every type of medical care available, the nursing home is perhaps the form of service most associated with the aged, and the most dreaded. At any time, only about 5 percent of the elderly population live in nursing homes, but it is estimated that in 1972 over 25 percent of deaths of those over 65 occurred in nursing homes (or brief hospital admissions from a nursing home facility).[2]

As the elderly population (and especially the population over age 75) increases, the costs of nursing home care are likely to continue to grow both absolutely and relatively. Periodic exposés aired both in Congress and in the popular press[3] force recognition that the infusion of money into nursing home care has not assured quality but has perpetuated a marginal system of care.

THE NURSING HOME SCENE

Some terminology is necessary at the outset. Nursing homes in the United States imply some form of supervised care for medical and medically-related problems; the term embraces those facilities which offer skilled nursing care, those which are personal care homes, and those with intermediate levels of care. For the most part, the level of care is defined by the level of nursing effort required. A large proportion of those found in nursing homes in the United States would in other countries be served in old age homes under social service auspices; under those circumstances, the term "nursing home" is reserved to connote a more chronic hospital situation funded under health auspices.

The nursing home, in turn, is categorized as a "long-term care" facility. Technically long-term care alludes to any care for a chronic problem on either an ambulatory or institutional basis; in practice, the term is used to refer to a prolonged service in a chronic care institution or its equivalents. A major point of contention currently is the definition of an "equivalent" to chronic institutional care. Suggestions include combinations of home health care, geriatric day centers and day hospitals; much work is still necessary to determine whether such equivalents are truly substitutive for the nursing home or whether they are added requirements applicable to specific segments of a comprehensive health program for the elderly.

As seen in Table 1, the nursing home differs substantially from the typical hospital. In 1973, there were 21,834 nursing homes in the United States with over a million and a quarter beds. (The maldistribution of this resource is shown by the over fourfold range in the number of beds per 1,000 people over age 65 in 1973 from 89.5 in North Dakota to 21.1 in West Virginia.) Only about two-thirds of the nursing homes in the country offered at least some nursing care. Again in 1973, facilities with nursing care had 51 employees per 100 beds while personal care homes had 35.

Table 1: Comparison of Sample Statistics for Nursing Homes and General Medical and Surgical Hospitals, 1973.

	Nursing Home	Hospital
Number of Facilities	21,834	6,458
Number of beds	1,327,704	1,030,432
Average number of beds per facility	61	160
Average number of personnel per 100 beds	64	243
Percent proprietary	77%	13%

Source: DHEW, National Center for Health Statistics. Health Resources Statistics, 1975, U.S. Government Printing Office, Washington DC, 1976. DHEW Pub, No.(HRA)76-1509.

Payment for nursing home care is a major governmental undertaking In FY77, $12.5 billion went for nursing home care of which $4.0 came from federal sources and $2.9 from state and local governments. These expenditures can be primarily traced to the Medicare and Medicaid programs. The former is far more restricted, covering only limited stays (up to 60 days) in skilled nursing facilities. Medicaid is therefore the predominant payment source for nursing home care, drawing on a combination of both federal and state funds. Medicaid coverage extends to both skilled and intermediate level nursing homes. Table 2 compares a sample of nursing homes participating in these programs.

The bulk of nursing homes are owned by private proprietors; in 1973 74 percent of the homes and 68 percent of the beds were in proprietary hands, while 22 percent of the beds belonged to nonprofit organizations and 10 percent belonged to the government, primarily the federal government. The size of the nursing home varies according to its classification as a skilled facility or a personal care home--only 16 percent of the former but 72 percent of the latter contained 25 or fewer beds. In contrast 60 percent of skilled nursing homes and 16 percent of personal care homes contained 50 or more beds.

Table 2. Selected Characteristics of United States Nursing Homes by Certification Status

Operating and financial characteristics	Both Medicare and Medicaid[1]	Medicaid Only		Not certified
		Skilled nursing homes[2]	Intermediate care facilities	
Number of homes	4,200	3,500	4,400	3,600
Average bed size	105	92	57	45
Average total FTE employees per 100 beds	68.2	76.3	55.8	56.7
Nursing FTE employees per 100 beds	44.4	42.8	35.0	32.5
Average occupancy rate	85.6	89.2	89.2	89.0
Average length of stay (years)	1.1	1.7	1.9	2.1
Percent live discharges	74.9	66.3	66.3	52.7
Percent proprietary	77.0	72.0	79.0	73.0
Average total monthly charge per resident	$592	$484	$376	$329

[1] 8 percent of these homes were certified for Medicare only.

[2] 35 percent of these homes were certified as both SNHs and ICFs.

Source: DHEW National Center for Health Statistics Series 13 No.22 (1975) and No.28 (1977).

Although the nursing home industry is a large employer (of over 635,000 people), its personnel tend to be less well paid, less trained, and less satisfied in their work than those in other parts of the health care system. Professional nursing coverage is minimal and other professional staff usually serve the nursing home on a part-time consultative basis. Physicians maintain even more independence of the institution where they attend when that institution is a nursing home than they do in the hospital. Social workers, occupational therapists and other professionals appropriate to serve a setting where social needs are so admixed with health needs are in short supply and are often hired on a consultation basis similar to the physician.

NURSING HOME RESIDENTS

The nursing home has become a last resort for a variety of problems--nursing homes are utilized by terminally ill individuals requiring intensive nursing care, recuperating patients needing briefer convalescence, and less ill but infirm aged who lack social resources sufficent to manage in the community. Nursing home residents vary enormously along a continuum of physical impairment and mental disorientation. The wholesale removal in the 1960's of long-term elderly patients from state mental hospitals has produced a substantial number of nursing home residents with a primary psychiatric disorder other than senility.[4] In this way the social reform of one decade has become part of the social problem of the next.

While only 3 percent of the general population is over age 75, in 1974 almost 75 percent of the residents of nursing homes that provided at least some nursing care had attained that age. A disproportionate number of nursing home residents are female and are widowed or never have been married. Among those who are married, childless individuals predominate.[5] As far as one can ascertain, it is a myth that adult children of this generation are devoid of family feeling and readily able to consign elderly parents to a nursing home. Despite all the pressures of a mobile society in which both men and women work outside the home, families do rally around to try to maintain elderly relatives in the community. A recent Boston study, for example, showed that 70 percent of intact families in the sample were willing to receive into their homes severely disabled family members who were returning from the hospital for the first time. This was in spite of the fact that much personal care was needed and the vast amount of recommended service was provided physically and financially by families with no help from outside social or health agencies. After the second hospitalization, however, of these same disabled relatives, only 38 percent of the sample was willing to continue to provide care without social supports.[6] In the absence of these social supports families take reluctant recourse in the nursing home.

Nursing home residents tend to suffer from multiple chronic conditions--in 1969, over 60 percent of residents had three or more conditions. A preponderance of mental disability was present, including 34 percent with advanced senility, 28 percent dubbed in the statistics as having "less serious senility" and 17 percent with other mental conditions; the latter has probably increased substantially because of the policy of removal from state mental hospitals. Despite mental health problems both as admitting diagnoses and attendant on admission to a nursing home, mental health services are scarce in these facilities. New technology such as reality orientation to reduce problems of senility is not common, nor is treatment for the reactive depression so frequent in the age group. Little social planning takes place to minimize the effects of mingling the mentally alert with the group euphemistically referred to in Britain as "mentally frail." Heavy doses of psychoactive medication are commonly used. Paradoxically patients whose primary diagnosis is medical may receive more psychoactive drugs than those with primarily psychiatric problems.[7]

HOSPITAL OR OLD AGE HOME

If not the natural heir to the social responsibility for the elderly, the nursing home has become the de facto answer to fill a void formerly handled by family members in a less complex and mobile era and partially filled by government social services and personal health services in European countries. Like many products of mixed marriages, the nursing home faces a severe identity crisis. It is far from clear whether its dominant lineage is medical or social. While most of the regulations for nursing homes seem to cast the facilities as miniature hospitals, most of the problems are more social than medical.

Judged as a hospital, the nursing home comes off poorly. It lacks the technical base of both machinery and manpower. The hospital's emphasis on professionalism and the concomitant assumption that the availability of resources is a close proxy for their appropriate use is not a protection which can be equally applied to the nursing home. The nursing home is not simply a scaled down hospital; it differs in a number of important respects; problems are more chronic than acute and treatment

rather than diagnosis is the order of business. Patients are less transient boarders than lifetime residents. While most hospitals are structured as nonprofit corporations, most nursing homes are run under proprietary auspices. In the hospital, a lively power struggle often exists between medical authority and administrative authority; in the nursing home this balance is not maintained since the physician receives few intellectual rewards and little professional prestige from association with the nursing home. Physicians may react with disinterest and at times avoidance, with the blatant exception of those who exploit the market potential of the nursing home industry.[8]

There has been steady pressure to upgrade the standards of nursing home care by stricter regulations and a simultaneous drive to limit expenditures. Reform proposals have concentrated on ways to reduce fraud and improve the level of care provided. Unfortunately, the medical model response, which emphasizes staffing standards, care plans, and audit of results, cannot be transferred from hospital to nursing home without a commensurate commitment to increased costs. Moreover, such an investment would be made without any firm basis to anticipate that the course of nursing home patients can be ordered along the lines addressed by hospitals.

The modern hospital has already been indicted as a monument to technology, characterized by advanced equipment, division of labor, sterility, and inhumanity. It may be "a nice place to visit" for a short time with the expectation that sacrifices in dignity, comfort and personal choice are in the interests of receiving excellent diagnostic and curative services, but most former hospital patients would assert that they "wouldn't want to live there." Making more adequate hospitals out of our present nursing homes may in the long run be an inhumane solution to the social problem.

LONG-TERM CARE IN OTHER COUNTRIES

A valuable lesson about long-term care can be gleaned from the experience of several European countries. Observations both of differences in approach from the United States as well as some similarities in problems provide a perspective on the issues that face us in this country.[9]

In European countries where long-term care is well-developed, it is usually under government sponsorship; the most common pattern is that institutional care is under local government control with conformity to national guidelines. Even in the Netherlands, where health care is still in private hands, nonprofit status is a prerequisite. Control by local government also permits more equity in salary benefits, eliminating differential rewards to hospitals in comparison to nursing homes and health departments.

Moreover, in countries where nursing homes are a well-established form of institutional care, they are more adequately funded than in the United States. The cost per day for a nursing home bed is on the order of 40 percent (Sweden) to 50 percent (Netherlands) of the cost of an acute care hospital bed compared with a figure like 10-15 percent in the United States. However, the average length of stay in European hospitals is about twice that of American hospitals; this longer stay could substantially reduce the relative cost of a European hospital day.

Comprehensive planning for long-term care abroad often is cast in terms of ideal models or goals, against which reality can be measured. Figure 1, an example of such an ideal plan in Scotland, illustrates differences in emphasis which place institutional care in a broader perspective among various alternative modes of service delivery. Although geriatrics is a well-developed and growing medical specialty in Great Britain, the first line of primary care for the elderly is envisaged as the responsibility of the primary care practitioner. An active home health program is also conceived as essential and is buttressed by a state-supported home help program administered and

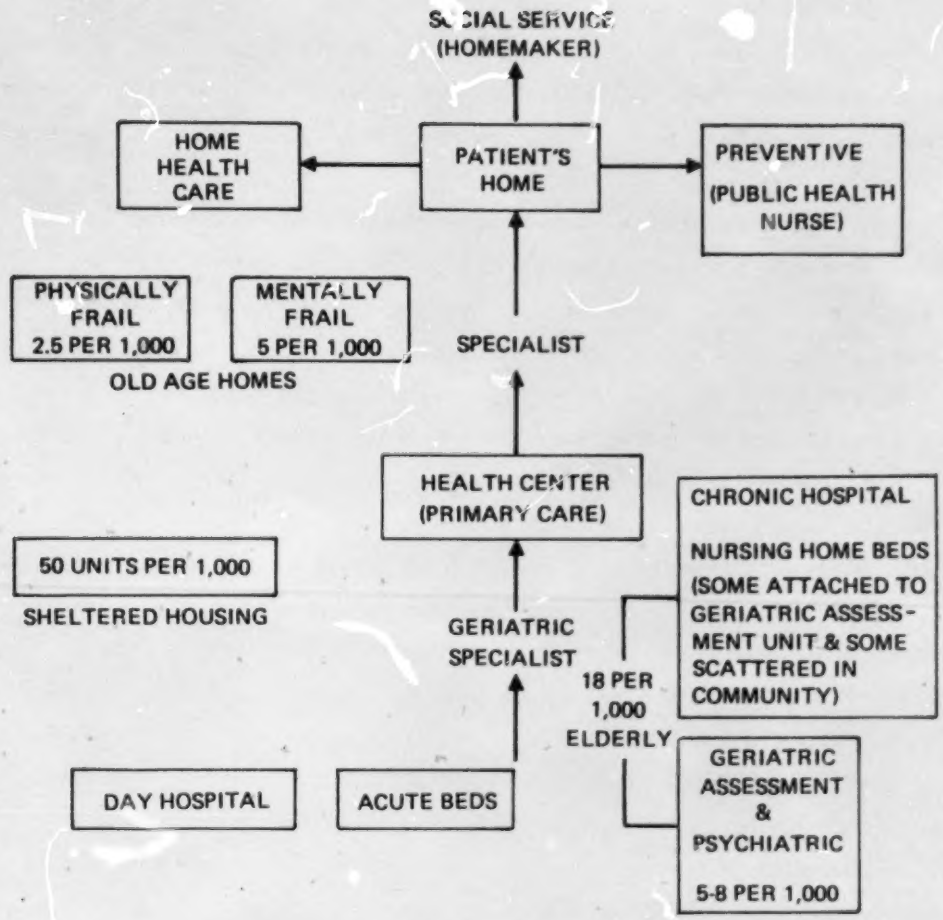

Figure 1: Model of services to the elderly in Scotland, 1974.

(Adapted from the writings of Dr. Ferguson Anderson with terminology changed to reflect American usage.)

staffed by social services. Another important component of the model is the preventive work of the health visitor, a public health nurse who identifies and visits high-risk individuals.

For those who cannot be maintained independently in the community, an alternative is sheltered housing, a protected form of community living which enable individuals to live in apartment complexes or detached cottages but receive supportive services; a typical sheltered housing scheme might provide a centrally prepared and served hot meal at noon, shopping services and distribution of provisions for individual apartments, an alarm system to notify a manager any time a medical emergency might arise, and a variety of recreational options. The Scotland projections call for development of 50 such units for every 1,000 persons over age 65; this is in contrast to the more modest estimation of requirements for old age home and nursing home beds (a total of less than 20 per 1,000).

The institutional care provisions in the model are divided between old age homes administered by local social services with provision of medical care from primary health care sources and chronic hospitals under the health department which are served by geriatric medical specialists. In the Scottish plan, about 8 beds per 1,000 elderly are proposed for time limited in-patient geriatric assessment, leaving 10 beds for long-term hospitalization and 7.5 for old age homes. Clearly the home health and sheltered housing programs are meant to eliminate much of the need for institutional beds. It is noteworthy, however, that in Scotland and elsewhere, old age homes administered under social services often house sicker patients and boast more nursing staff than skilled nursing homes in the United States.

We have reviewed this example of one national plan at some length to illustrate how the parts of a system of long-term care are clearly interdependent. Partly because of this interdependency, problems inevitably arise in practice. Five problematic themes seem to recur, even in countries with well developed long-term care systems:

1. Accelerating costs within a finite set of national health and social service resources produce budgetary strain. With universal entitlements, the only means to control costs is to limit access and/or recruit voluntary labor. Bottlenecks tend to develop which impede an easy flow of patients between acute hospital, old age home, chronic hospital, and sheltered housing.

2. With the recognition of long-term care as a social problem, social service departments are responsible for some institutional care, day care centers, and the home help and personal social services underpinning home health. Communication and coordination between health and social service departments on a local level is often a problem.

3. The style of care varies greatly with the auspices of care. When care is viewed in the medical domain, emphasis is placed on more traditional diagnostic and treatment activities with relatively little attention paid to the problems of comfort and adaptation. On the other hand, the social service operated institutions tend to pay far more attention to the comfort of patients but seem reconciled to more supportive and less rehabilitative goals for patients.

4. Although equalization of rewards has reduced some of the turnover of personnel characterizing American nursing homes, selection and training of staff is a continuous problem. In rural areas, given prevailing wage rates, it is difficult to retain the staff necessary to mount adequate home health and day care programs, nor do the less populous areas generate the revenue necessary to support the full range of desired service.

5. Only scant data are available to identify those programs that are effective in terms of reducing mortality and morbidity and/or improving quality of patient life. Without basic information about effectiveness, it is impossible to discuss the relative cost-effectiveness of various institutional programs or of community programs compared to institutional programs. Long-term care programs cry out for carefully designed studies of outcomes.

IMPLICATIONS IN THE UNITED STATES

The United States has not yet resolved many of the basic conflicts around long-term care. The current status of the American program suggests a value system at variance with both the European stance and our own espoused goals. We have addressed our willingness to support elderly citizens more by incremental default than by positive programs designed to provide comfort and dignity. To some eyes it may appear that our efforts on behalf of those in the unproductive phases of their life cycle have been designed to protect the more productive elements of society from burdens of providing direct care.

The moral discourse in this area is obscured by the relative invisibility of the American nursing home. There is evidence both at home and abroad that when an institution for the elderly engages interdependently with the surrounding community, standards of care go up.[10] If we look to market forces to improve the quality of nursing home life, we must provide better means of making informed choices by consumers or their advocates. This is an argument for encouragement of two-way volunteer activity between nursing home and community, integration of institutional and day care facilities, or of programs for the elderly with programs for children. When activities of nursing homes cease to be veiled not only is the home accountable to the community but the public becomes accountable to the elderly for conditions about which it cannot plead ignorance.

Nor have we resolved the question of eminent domain. The issue of predominance between the medical and social models for long-term care is not merely a battle for bureaucratic supremacy between two factions of government; it is a fundamental clash of beliefs in the style of life to be pursued and the appropriate manner of its pursuit. This conflict of credos involves questions of both ends and means--the goals and expectations generated by different perspectives and the paths deemed most approachable to reach them.[11]

Under the growing pressure of enforced fiscal austerity a choice is increasingly necessary; nor could providers and consumers tolerate the ambiguity resulting from assigning equal weight to both approaches.

The social model is attractive because it emphasizes that health care, albeit crucial, is just one of many services needed to raise the quality of life of the aged. Especially with an elderly population, the often dwindling benefits of heroic medical measures must be balanced against the heavy social and psychological costs. Morbidity and disability are conditions of life for the majority of aged people. A medical model allows the conditions to define a range of life circumstances. The very permanence and intractability of these health problems argue for societal provisions to protect the elderly from a permanent patient role for decades before their death.

Therefore, we favor subsuming the provision of health care under a social plan over the reverse, but we recognize that such a restructuring would be initially difficult in view of the prestige discrepancies between health care professionals and social service professionals in the United States.

Even in a socially oriented system some medical attention will be necessary. The current lack of interest among physicians in offering care to the elderly may be alleviated by one of two routes. Most consistent with the medical model would be an effort to upgrade the status of physicians who care for the elderly by developing a specialty of geriatrics. This path has been successfully pursued elsewhere but tends to reinforce those values held by the technologically oriented physician dominated system; it is not being pursued actively in this country at present.[12]

Another option is to utilize other forms of primary health care providers. The geriatric nurse practitioner offers a potentially attractive alternative.[13] The traditions of nursing lie closer to the nurturing requirements of long-term care, emphasizing health promotion and supportive activities over diagnostic emphasis. Early reports suggest that such practitioners may have a valuable role in providing primary care to both institutionalized and non-institutionalized elderly. Lessons from abroad argue strongly for the desirability of decentralization and local autonomy in administering long-term care.

If relatively small and ethnically homogeneous nations have needed local autonomy, the demand seems much greater in the United States with its vast distances and cultural diversity.[14] Local control facilitates simultaneous planning on all phases of care including primary care, acute care, home health, and institutional care.

Alternatives to institutional care are more likely to develop under such auspices.[15] Experimentation with sheltered housing in this country has been very promising[16] and should be expanded. Recognizing that long-term care is to a large extent a social problem, provisions must be made for the personal services, including homemaking, meal preparation, shopping, night sitting, laundry, and so on; these are not readily available at present. Here we face a problem which may be peculiar to North America where the performance of such personal services has not been valued. Either the general low regard for performing personal services must be somehow altered, or a uniquely American approach must evolve wherein these services will need to be professionalized, depersonalized and mass produced through technological and bureaucratic solutions.

A growing body of evidence suggests that, were adequate alternatives available, many people who are currently being institutionalized could be cared for without resort to nursing homes.[17] We advocate greater investment in home care and especially in various forms of sheltered housing as a means of keeping people out of nursing homes. However, the current lack of information about the outcomes of different interventions militates caution in urging simple solutions. One cannot safely promise, for example, that development of an effective home care system will drastically reduce the cost of institutional care--more money may be required by <u>both</u> home care and institutional programs in the future.

Although the profit motive has been largely removed from the long-term care scene in European countries with beneficial results, it appears infeasible, and not necessarily desirable, to suggest that proprietary motivations can be quickly removed from long-term care in the United States. We are, in fact, seeing an opposite trend with proprietary home health agencies and homemaking services springing up. A more pragmatic approach may seek ways of channeling the profit motive to provide proper incentives for a better standard of care.

Current and proposed methods of paying nursing homes offer all of the disadvantages of the general financing of health care with few of the safeguards usually assumed. All forms of fee-for-service or even cost reimbursement payment may be said to encourage perverse behavior. This potentially backwards incentive stems from the fact that the sicker the patient (i.e., the greater his care needs), the more we pay for his care. Ordinarily we rely on the high professional standards of the hospital or the provider to prevent exploitation, but the results of such an approach to funding has been inflation and frustration.[18]

The nursing home may be the ideal place to begin to reverse this approach. Several commentators have recognized the problem and suggested solutions[19] but none has gone right to the heart of the matter. We propose that nursing homes be paid on the basis of the actual outcomes of their patients. The precise method for accomplishing this requires that the status of each patient be assessed periodically (e.g., every six months) by independent reviewers. (A system of utilization review is already in place to examine less pertinent data.) Given the nature of the nursing home patient, the assessment must be a broad one with measures of not only physiologic parameters but also dimensions of overall functioning, social and psychological well-being and satisfaction.

In brief, the data would be used to calculate an expected course (a prognosis).[20] The actual outcome assessed at the next point in time (perhaps six months later) would then be compared to the expected outcome. If the patient did as well or better than expected, the home would be paid a sum greater than the estimated costs of care for that patient. If the patient did worse than expected, the home would receive less than cost. The cost calculation would be based on average care needs for a patient with the status identified at time one. A nursing home's income would then be the sum of payment for each patient.

It should be noted that because each patient is compared against his own prognosis, there is no incentive for skimming off patients with favorable prognoses. In fact the system could be used in a prospective mode whereby the expected outcome was negotiated with the home in advance and contractual agreement reached for a predetermined payment for a given outcome.

Such an approach to payment has several prerequisites but also several notable advantages. In order to carry off the technique, we must have a reliable means of predicting the expected course of nursing home patients. This need confronts our current lack of adequate data on outcomes. Fortunately we do have a number of tools by which to make many, if not all, of the necessary measures. The system also requires fair and honest data collection. Direct observation, rather than record review, by professionals not responsible for providing the care itself is essential. The preliminary work by several Professional Standards Review Organizations can serve as a model here. Finally, some mechanism for handling unpredictable events must be incorporated through some form of appeal procedure.

If the proposed system can be implemented, we will have an effective alternative to the current imposition of ineffective regulations.[21] If we can monitor outcomes, we are free to allow the institution more liberty to experiment with alternative (and hopefully more creative) ways of achieving good ends. The market forces should drive the poorer homes out of business and encourage the better homes to expand if average costs are used.[22]

Moreover, the suggested emphasis on outcomes would encourage an open examination of a series of social value questions. In the arena of long-term care we must find ways to choose between different dimensions of benefit (e.g., physiologic vs. social). Gains in one are likely to be achieved at the cost of losses in others. Techniques are available to begin to examine in an organized way our value system in this sphere.[23]

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$$\frac{.304 \times 1{,}077{,}500}{1{,}237{,}144} = 26\%$$

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